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TEXAS HOSPITAL ASSOCIATION

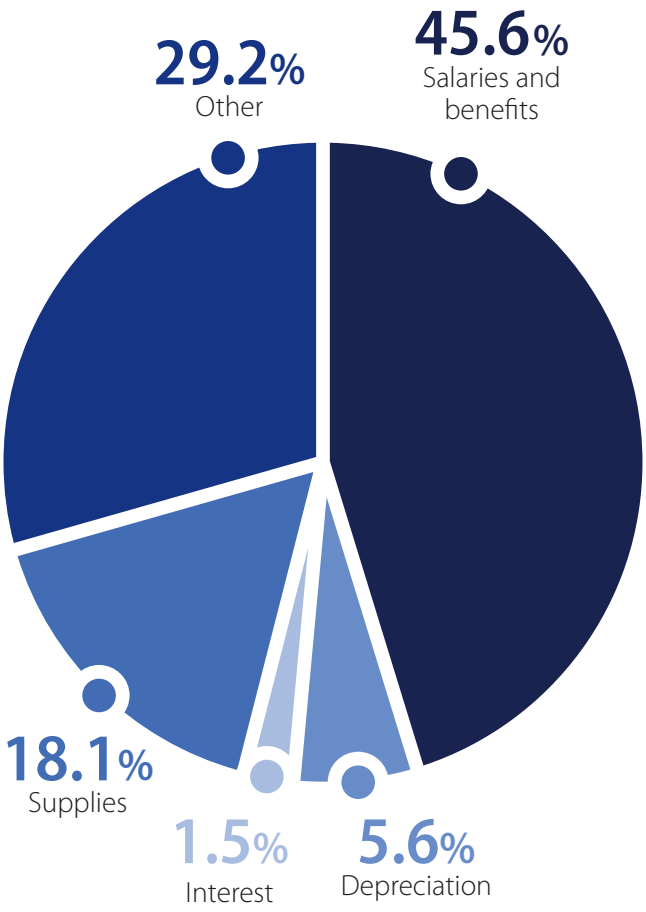
Hospital Financing Overview

Under federal law, hospitals are required to provide care to anyone who seeks it in their emergency departments, regardless of the individual's ability to pay. However, while an altruistic purpose is central to any individual or institution involved in health care delivery, hospitals must have stable, adequate and reliable sources of funding to be able to do their work.

This document is intended to provide a high-level overview of the hospital financing system in Texas and the challenges that exist – challenges that threaten hospitals' continued ability to provide the highest quality care for all Texans.

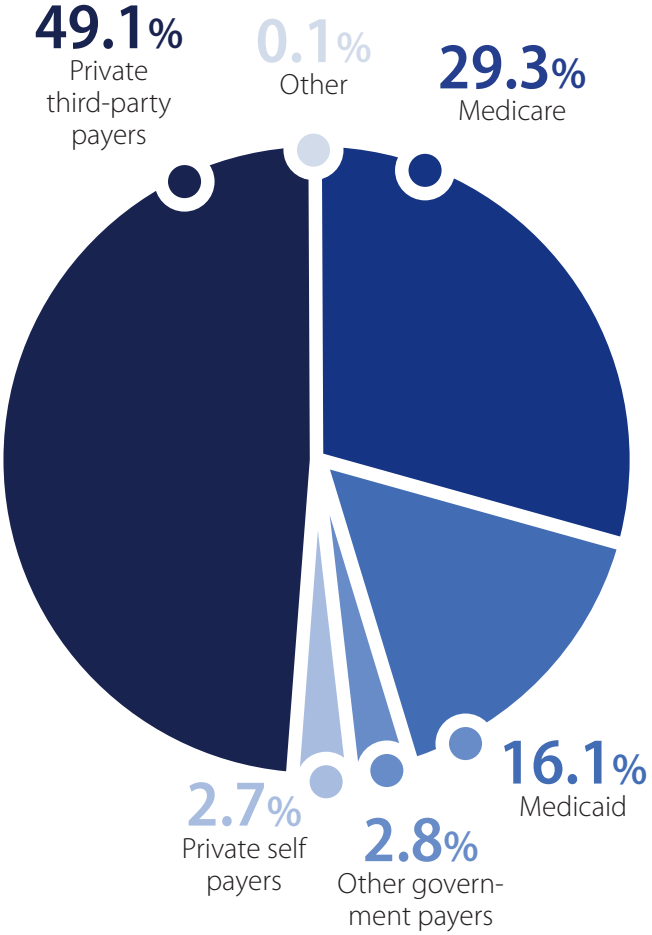
Overview of Hospital Costs

Health care delivery requires a highly skilled, trained workforce. From nurses and therapists to technicians and administrative staff, today's hospital workforce is diverse and multifaceted. Labor costs are by far hospitals' largest expense. In 2014, salaries and benefits for Texas hospitals' more than 350,000 employees totaled more than $27 billion and constituted 45.6 percent of expenses.



Overview of Hospital Payments

Payments for health care services provided in the inpatient and outpatient settings of Texas hospitals come from multiple sources, including government payers and programs, private insurers and self-pay patients. For Texas hospitals, the largest source of payments is private third-party, non-government payers who provide nearly half of all payments for services.



Overview of Hospital Payments (continued)

Hospitals almost never receive full payment for the actual cost of providing a health care service. Reimbursement methodologies and payment amounts for services vary widely, depending on the payer. This means it is not uncommon for different payers to pay different amounts for an identical service.

Medicare uses a Prospective Payment System for inpatient and outpatient services. The inpatient PPS uses diagnosis related groups to establish a pre-determined payment for specific conditions. Every diagnosis is assigned a weighting factor. The standard payment amounts vary among hospitals, based on certain characteristics, such as teaching status and geographic location. The inpatient and outpatient PPS applies to most Texas hospitals. However, hospitals designated as critical access hospitals are not included in either the inpatient or outpatient PPS systems and receive 101 percent of costs for Medicare-covered services.

Medicare pays Texas hospitals, on average, less than 93 cents for every dollar spent on care for a Medicare beneficiary. This amount has been decreasing each year since 2009 while the number of hospitals experiencing negative Medicare margins has been increasing. In 2009, 57 percent of hospitals had a negative Medicare margin; by 2014, the proportion had increased to 80 percent.

Medicare Margins

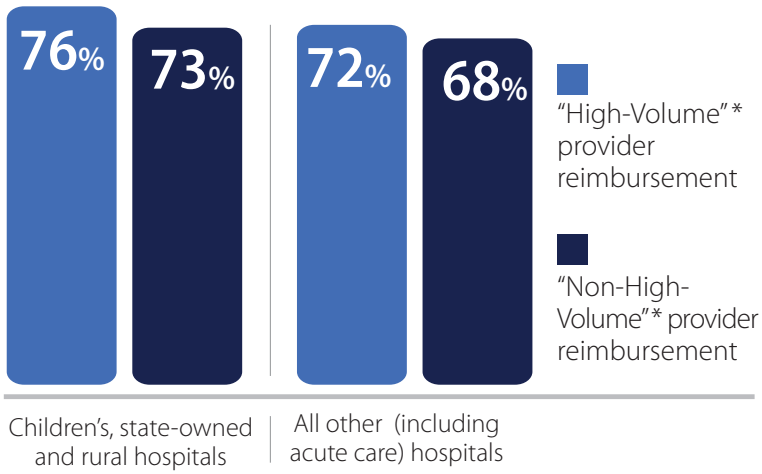
Texas Medicaid, through its fee-for-service system, uses a prospective payment system to pay for inpatient hospital services. This PPS is based on the All Patient Refined Diagnosis Related Groups (APR-DRG) patient classification system. Each patient is classified into a diagnosis related group on the basis of clinical information; hospitals then are paid a pre-determined rate for each DRG (admission), regardless of the actual services provided. "Outlier" payments are made in addition to the base DRG payment for clients under age 21 whose treatments are exceptionally costly, or who have long lengths of stay. There are other add-on payments for trauma-certified and teaching hospitals and for safety-net hospitals.

For most hospitals, Medicaid reimbursement covers just 58 percent of the costs of providing inpatient services.

Outpatient hospital services provided to fee-for-service patients are reimbursed at a portion of the hospital's reasonable cost and are based on whether a hospital meets the state's definition of "high-volume" provider.

Medicaid Outpatient Reimbursement Compared with Costs

*The state categorizes "high-volume" hospitals as those that were paid at least $200,000 for fee-for-service and primary care case management Medicaid services during calendar year 2004.



Uncompensated Care

Nearly every hospital has at least some uncompensated care – costs of care already provided that are not fully reimbursed or compensated.

Historically, uncompensated care was calculated as the sum of hospitals' bad debt and charity care. The Texas Department of State Health Services reports uncompensated care amounts using this calculation. Based on this calculation, hospitals' uncompensated care costs in 2014 totaled $6.4 billion, an increase of 89 percent since 2003.

Texas hospitals have such a large amount of uncompensated care for two main reasons

19.1%

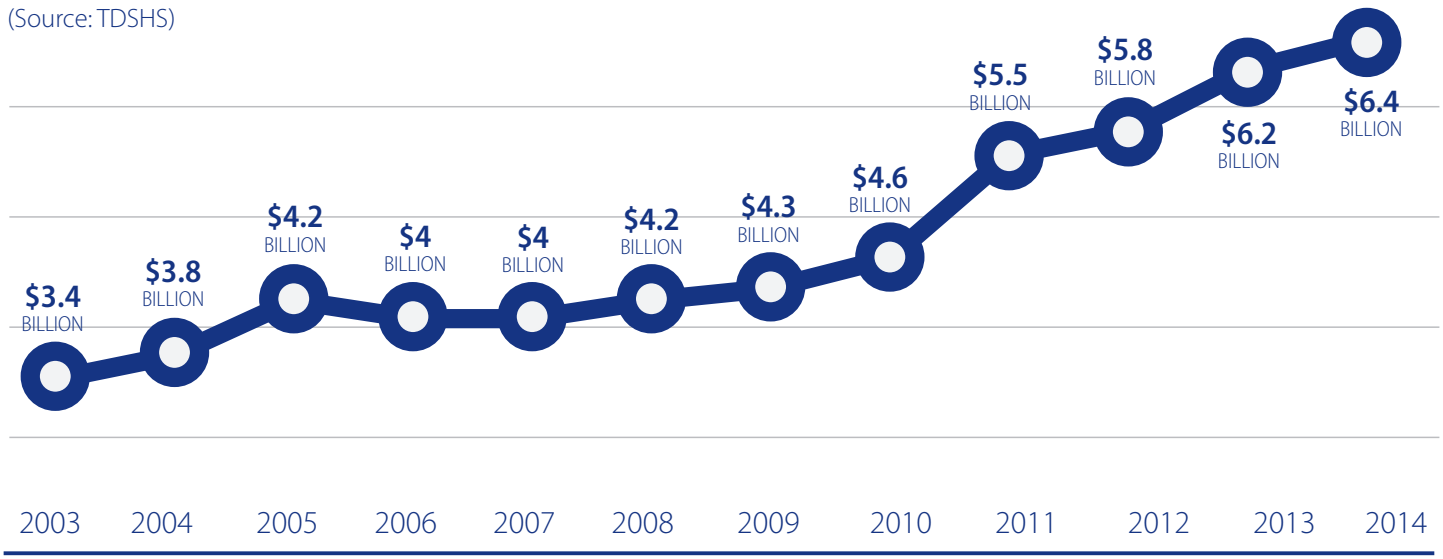
First, Texas has the largest number and proportion of residents without health insurance in the nation. **More than five million Texans – 19.1 percent of the state's population -- are uninsured.**

58%

Second, Texas Medicaid falls far short of covering the actual costs of providing health care services to Medicaid enrollees. As discussed above, **Medicaid reimbursement covers only 58 percent of actual costs.**

Texas Hospital Uncompensated Care Costs Since 2003 (bad debt & charity care)

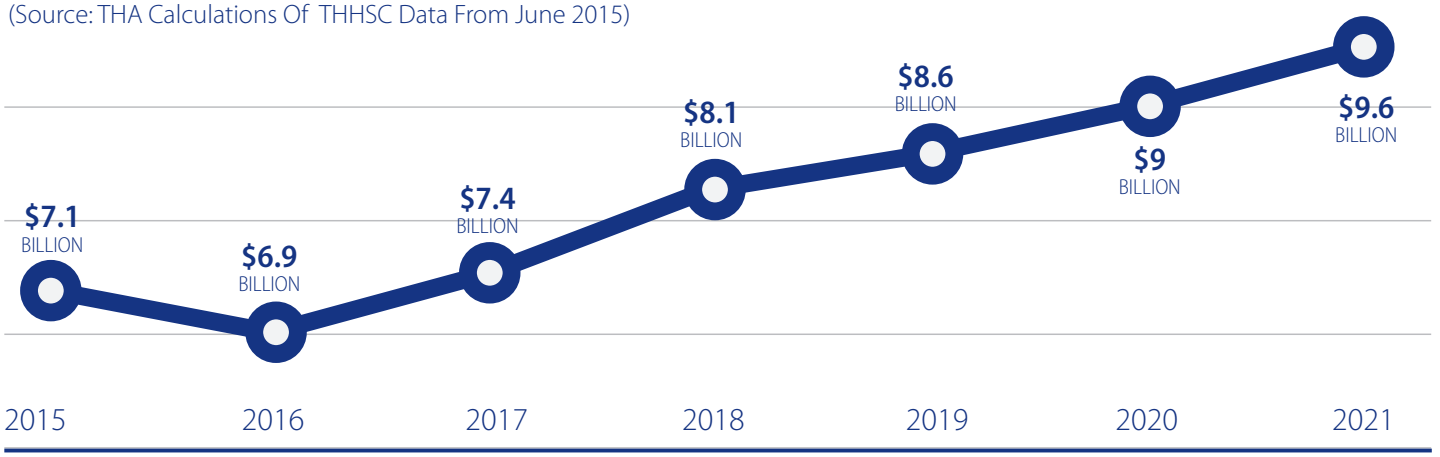
(Source: TDSHS)



Under the rules required by the transition to the 1115 Medicaid Transformation Waiver and the **uncompensated care** pool in 2011, hospitals now calculate uncompensated care differently -- as the **sum of their Medicaid shortfall and uninsured costs** -- through the use of single, uniform, cost-based methodology. Using this calculation, total uncompensated care costs in 2015, before DSH or UC pool payments, totaled $7.1 billion. This amount is projected to increase to $9.6 billion by 2021. Hospitals are allowed to include certain physician, pharmacy and clinic costs associated with their facilities. In addition, limited ambulance and dental costs are included in the UC pool distribution.

Projected Uncompensated Care Costs 2015-2021 (Pre-Supplemental Payment Offsets)

(Source: THA Calculations Of THHSC Data From June 2015)



Uncompensated Care Glossary

Bad Debt: Debt that is unlikely to be paid or that is not collectible, although a patient has the ability to pay. Bad debt can include the full charge for a service or just the copayment or deductible owed.

Charity Care: The unreimbursed cost to a hospital for providing, funding or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as financially or medically indigent.

Medicaid Shortfall: The difference between Medicaid reimbursement and the cost of providing care to a Medicaid-insured patient.

Uninsured Costs: The unreimbursed costs to a hospital of providing care to those without a third-party source of payment.

Supplemental Payments

Given the large shortfall between Medicaid payments and the cost of services and the large number of uninsured Texans, supplemental payments are an essential component of financing for Texas hospitals. Currently, there are three types of supplemental payments for which hospitals may be eligible:

1. Disproportionate share hospital payments (DSH); and
2. Waiver payments:
   a. Uncompensated care pool (UC) payments; and
   b. Delivery System Reform Incentive Program (DSRIP) payments.

However, in order to receive UC, DSH and DSRIP payments, there **must** be sufficient **non-federal** funds to support the payments. As with other Medicaid services, the federal government and the state are required to contribute to these payments. In Texas, however, the state share is funded almost entirely by intergovernmental transfers from public hospitals. (see section below on financing the non-federal share of Medicaid payments)

Each hospital has its own "hospital-specific limit," established by the Texas Health and Human Services Commission. The HSL is the sum of the hospital's Medicaid shortfall and the unreimbursed costs of caring for low-income, uninsured individuals. The HSL is a ceiling. Hospitals may receive DSH payments up to but not exceeding their individual HSL.

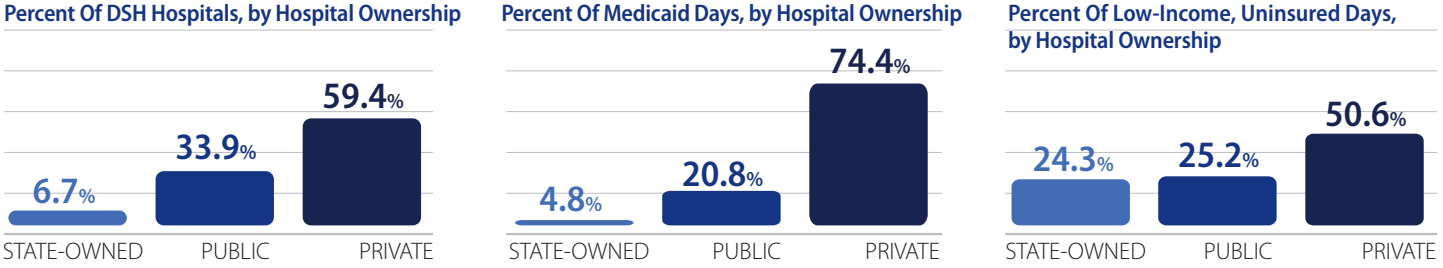
DSH: Federal law requires state Medicaid programs to make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients. Under the so-called DSH program, roughly 180 Texas hospitals receive these supplemental payments, worth more than $1.8 billion.

Each year, the federal government establishes a Medicaid DSH allotment for each state. This allotment represents the maximum amount of federal Medicaid DSH funds a state can receive. As with other Medicaid services, the state draws down federal DSH funds by making state expenditures. For FY 2015, the federal Medicaid DSH allotment for Texas is approximately $1.03 billion. The state share is approximately $723 million.

Among all DSH hospitals, private hospitals -- not public hospitals -- provide the vast majority of Medicaid inpatient days (74.4 percent) and the majority of low-income, uninsured inpatient days (50.6 percent).

DSH payments are made based on each hospital's sum of Medicaid and low-income uninsured days as a proportion of all qualifying DSH hospitals' sum of Medicaid and low-income uninsured days.

Breakdown of DSH Hospitals and Care Provided, by Ownership Type



(SOURCE: THHSC)

Supplemental Payments (continued)

The federal health care reform law, the Patient Protection and Affordable Care Act, required a reduction in the federal DSH allotment for each state as the number of uninsured Americans was expected to decline dramatically in response to the insurance coverage provisions of the law. Beginning in federal fiscal year 2018, DSH reductions for all states will total $2 billion; the reduction will increase each year through 2025 to $8 billion. The specific DSH reductions for Texas are unknown at this time but are anticipated to be significant.

UC: Uncompensated care payments are part of the state's Medicaid 1115 Transformation Waiver. Since 2011, more than 330 qualifying Texas hospitals have been eligible for payments from a funding pool of more than $17.5 billion over five years. The current waiver expires on Sept. 30, 2016. CMS recently granted Texas a temporary, 15-month extension, which will continue UC pool funding through December 2017.

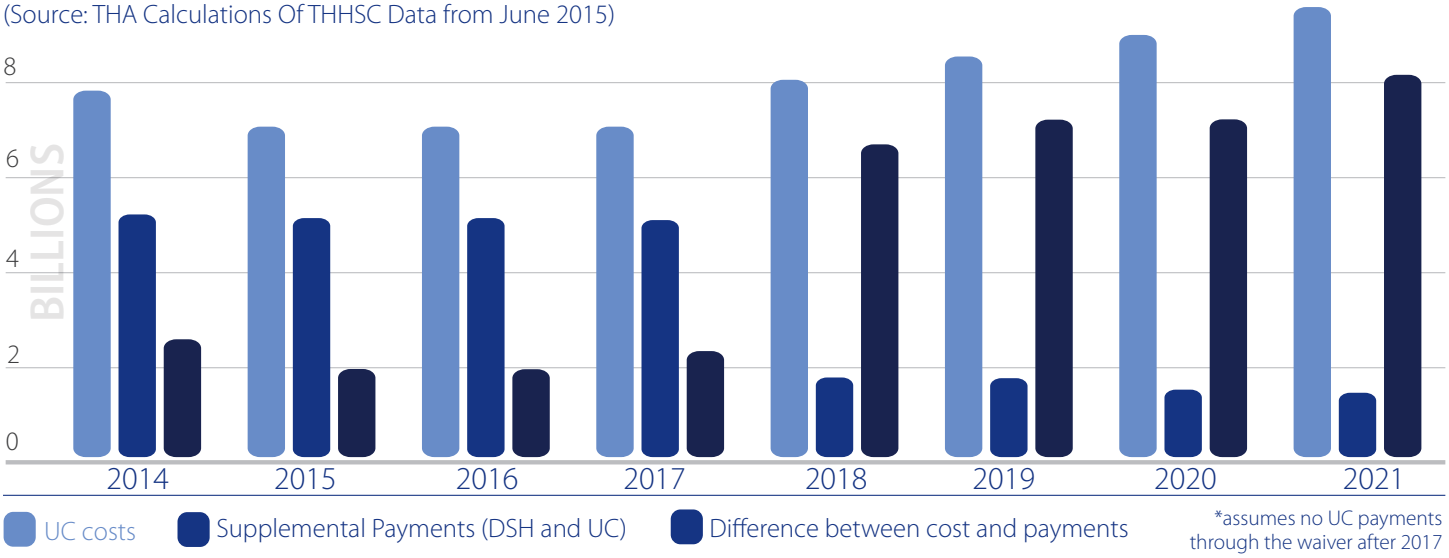
UC and DSRIP Payments, 2011-2017

Medicaid 115 Waiver Funding	Year 1 (2011-12)	Year 2 (2012-13)	Year 3 (2013-14)	Year 4 (2014-15)	Year 5 (2015-16)	15-Month Extension (9/2016-12/2017)
UC	$3.7B	$3.9B	$3.354B	$3.348B	$3.1B	$3.88B
DSRIP	$500M	$2.3B	$2.666B	$2.85B	$3.1B	$3.88B
Total/Year	$4.2B	$6.2B	$6.2B	$6.2B	$6.2B	$7.75B
% UC	88%	63%	57%	54%	50%	50%
%DSRIP	12%	37%	43%	46%	50%	50%

Texas hospitals face a steep fiscal cliff once the temporary extension of the waiver expires in December 2017. Absent a new agreement between CMS and THHSC, UC payments will be dramatically reduced, creating a gigantic budget hole for the majority of Texas hospitals. By our calculation, UC payments will be reduced from the current $3.1 billion a year to $1.2 billion.

Uncompensated Care Costs vs. Available Supplemental Payments*

(Source: THA Calculations Of THHSC Data from June 2015)



*assumes no UC payments through the waiver after 2017

DSRIP: As shown in the table above, DSRIP funds have been a growing percentage of total waiver dollars over the life of the waiver. Hospitals and other DSRIP providers (i.e. local mental health authorities) must earn these dollars by meeting metrics and performance outcomes. If projects are not successful according to these metrics, hospitals do not earn DSRIP dollars. This is particularly important because many DSRIP projects required hospitals and other providers to invest a significant amount of their own funds up front to get the projects designed and implemented. DSRIP performing providers report twice a year on project metrics and milestones, as agreed upon by THHSC and CMS.

As with UC payments, DSRIP dollars also are vulnerable if a new waiver agreement is not reached. In the absence of an agreement, DSRIP payments will be completely phased out beginning in 2018 through 2021.

Financing the Non Federal Share of Medicaid Payments

Texas traditionally has relied on the largest public hospitals in the state to provide the state share of Medicaid DSH, UC and DSRIP funds necessary to draw down federal funds. Through "intergovernmental transfers (IGTs)," a local governmental entity – in Texas, primarily public hospitals – make a transfer of funds to the Texas Health and Human Services Commission.

In 2013, for the first time, the state legislature appropriated state general revenue funds averaging $150 million for FY 2014 and 2015 to alleviate some of the burden on the public hospitals to finance DSH payments. Nonetheless, the burden on the public hospitals totaled $395 million in FY 2014. These state funds have not been maintained. As a result, today, the full cost of the state share for DSH payments to non-state owned hospitals falls to the public hospitals. At the same time, the full state share of UC and most DSRIP payments for non-state hospitals is borne by public hospitals.

Public hospitals' continued ability to provide this essential IGT is at risk for a number of reasons:

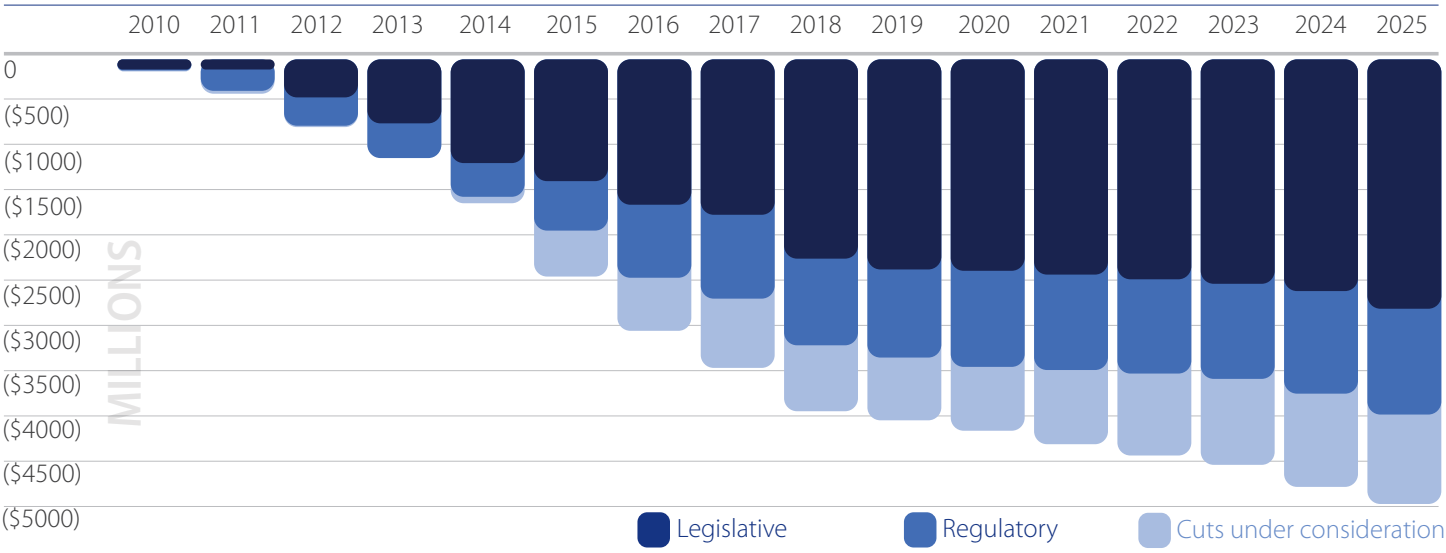
1. Growing pressure to stabilize or even reduce local property taxes;
2. Persistently high number of uninsured;
3. State funding cuts, including 10 percent reduction in Medicaid inpatient and outpatient reimbursement rates; reduction of facility payments for use of the hospital ER for non-emergent reasons; elimination of payment for elective deliveries before 39 weeks; and reduction of reimbursement rates based on potentially preventable adverse events; and
4. Federal funding cuts, including prolonged Medicare sequestration.

ACA Funding Cuts

The federal health care reform law, the Patient Protection and Affordable Care Act, aggressively reduced hospitals' funding. For Texas hospitals, the revenue loss between 2010 and 2025 as a result of all the ACA's funding cuts is estimated at more than 14 percent. Importantly, this does NOT include the anticipated cuts to Medicaid DSH payments as discussed above. When those cuts take effect, the impact on Texas hospitals will be even greater.

The cuts to hospitals and other providers financed the provisions of the law intended to give more Americans access to affordable health insurance, including increasing access to the Medicaid program for childless adults. Lawmakers anticipated a major reduction in hospitals' uncompensated care as a result of many fewer uninsured patients. However, in Texas, the reduction in the number of uninsured patients and uncompensated care has been much less than in other states, in large part because the state has not accepted federal funds to give low-wage working Texans access to health insurance. The result is that Texas hospitals are sustaining funding cuts without the accompanying benefit of a reduction in uncompensated care.

Estimated Value of Enacted ACA Funding Cuts & Cuts Under Consideration



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